RS-3e (7/03)

Commonwealth of Virginia Department of Rehabilitative Services
Authorization for the Release of Confidential Information

Return information to *(counselor and address)*

Mail to:

(1) I *(print name of consenting person)* _____ am signing this form for
(print consumer full name) _____ of *(consumer address)*

(2) Relationship to consumer *(check one)*: Self ☐ Parent ☐ Power of Attorney ☐ Legal Guardian ☐

(3) Consumer DOB _____ (4) SSN (*optional*) _____

(5) By signing this form, I/my representative am authorizing the information specified in Number 6 to be:
Released to the Department of Rehabilitative Services ☐ Released to/shared with the following agency or individual(s) ☐ *(name)* _____

(6) The following information may be disclosed . _____

(7) I want information to be shared through the following means or mechanisms *(check all that apply):*
Written information ☐ In Meetings or by Phone ☐ Computerized Data ☐

(8) This consent includes information placed in my records after the signature date: Yes ☐ No ☐.

(9) I understand that my records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in law or regulations. I understand that this consent does not cover the release of protected health information or alcohol or drug treatment information. I understand that if I have reached the age of 18 and am not under a legal guardianship, that my parents/guardians cannot have access to information in my case file and cannot discuss my case with DRS or make decisions regarding my case without my express, written consent. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance of a signed form. **This consent automatically expires as described below or no later than one year from the date of signature, whichever is sooner.**

(10) Expiration Date _____ Event or condition upon which this authorization expires:

(11) Signature(s) _____ _____ Date _____
(12) Person explaining form, title _____ Phone _____
(13) Witness signature *(if required)* _____ Date _____
Witness address _____ Phone _____

For DRS Use Only

Consent has been: Revoked in entirety ☐ Partially revoked as follows ☐ (*specify below*

Consent revoked on *(date):* _____ by Letter ☐ *(attach copy)* Phone ☐ In Person ☐

Agency rep. receiving request *(name, title)*: _____
Office _____ Phone _____ Fax _____